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THE HAMPDEN HIPPOCRAT

JANUARY-FEBRUARY 1991
VOLUME XXXV NO. 12

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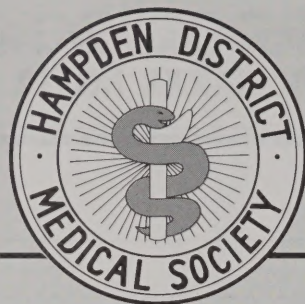
On our cover is Mary Lane Hospital in Ware, Massachusetts. See related article on page 8 in this issue.

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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HAMPDEN DISTRICT MEDICAL SOCIETY 1990-1991 SEASON

DISTRICT MEETING

PLACE: RAMADA HOTEL
(formerly Sheraton West)
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DATE: Tuesday, January 22, 1991

BUSINESS MEETING: 6:00 p.m.

SOCIAL HOUR: 7:00 p.m.

DINNER: 7:30 p.m., Spouses are welcome!

SPEAKER: JOHN J. RING, M.D., President-Elect
American Medical Association

SUBJECT: Major Medical Issue Update

NOTE: If you must cancel your dinner reservation, please call the office before noon on January 22nd. If the cancellation is not made, you will be BILLED for your dinner.

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From The MMS Regional Office

The Massachusetts Medical Society is preparing its first application for a new Health Manpower Shortage Area (HMSA) designation by the Federal government. The application will request designation for an area in Franklin County which includes the towns of Ashfield, Buckland, Charlemont, Colrain, Conway, Hawley, Heath, Monroe, Rowe, and Shelburne. This effort is guided by an Advisory Committee which includes MMS Vice President William Callahan, M.D. (Greenfield) as well as representatives from the Massachusetts Department of Public Health, Executive Office of Human Services, Massachusetts Hospital Association, Massachusetts League of Community Health Centers and the Area Health Education Center Program at the University of Massachusetts Medical School.

As defined by the federal government, a HMSA is a geographic area where there are not enough primary care physicians for the population they serve. To qualify as a HMSA, an area must have a population of 3500 or more per primary care physician. Additionally, services in contiguous areas must be overutilized, excessively distant, and/or inaccessible to the HMSA population.

A variety of program initiatives which are intended to address the problem of physician shortages are now being implemented by the Federal government. These include loan repayment programs the medicare reimburse-

ment bonus enacted by the Omnibus Budget Reconciliation Act of 1989 and revitalization of the National Health Service Corps. The Omnibus Budget Reconciliation Act of 1989 provides, as of January 1, 1990, a 10% Medicare reimbursement to any physician practicing in a Health Manpower Shortage Area. Up until now, physicians practicing in "high need" rural HMSAs have received a 5% bonus from the Medicare Part B carrier (in Massachusetts, this has applied only to Provincetown). The HMSA designations are used as a means of determining priorities in the allocation of resources, setting reimbursement policy, establishing physician placements and evaluating program proposals in these and other federal programs.

The Society has taken the lead in obtaining HMSA designations so that Massachusetts will be able to participate fully in these federal initiatives in order to address our own physician shortage.

Your comments or questions regarding the Health Manpower Shortage Area Designation Project can be addressed to David Pomeranz or Lisa Levine of the Health Care Policy/Systems Analysis Department in the Waltham office at 1-800-322-2303. ■

Lisa Levine

Health Care Policy/System Analysis Department
Massachusetts Medical Society

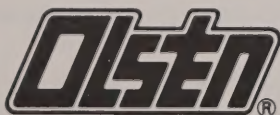
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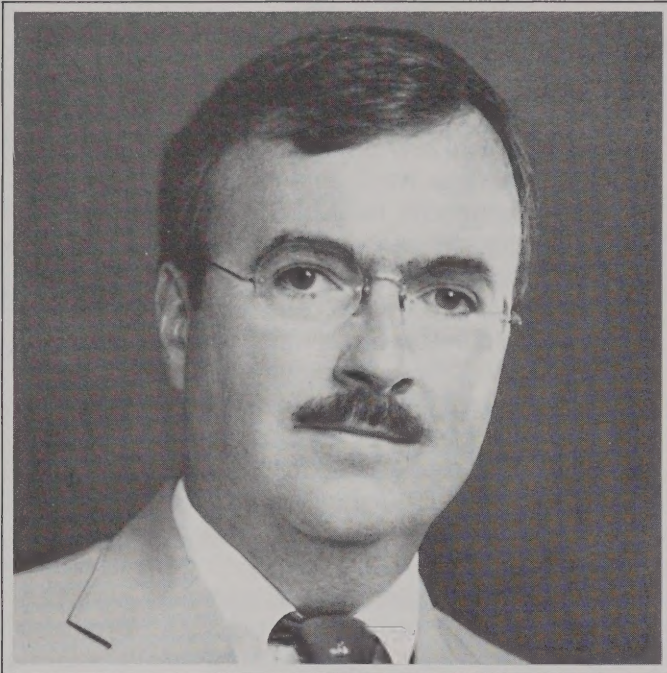
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HDMS President's Message



Joseph P. Keenan, M.D., President

I hope all of you have had a very enjoyable and safe holiday season and extend to you and your loved ones a very sincere wish for a happy and prosperous New Year.

The elections are over; what a relief! Now Governor-Elect Weld has to sit down and try to perform a miracle and salvage the economy of the state of Massachusetts. Among the other miracles he has to perform, he needs to bring about some change regarding the unfavorable climate for medical practice.

When Governor-Elect Weld spoke to the Hampden District Medical Society political candidates forum earlier this year, he seemed to have a great insight into some of the problem areas facing physicians in their attempt

to deliver high quality care to their patients in the state of Massachusetts.

Two areas he addressed were:

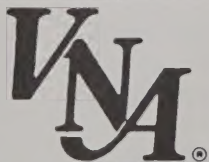
1. the general over regulation of physicians in the state and the consequent deleterious effect this has on the practice of medicine.
2. the need for meaningful tort reform. In other words, some other system has to be developed to compensate patients for maloccurrences as opposed to malpractice when people are injured as a result of the delivery of health care.

It will be interesting to see how aggressively he pursues these two when he takes office in January.

In November, I met with the President of the Hampden County Bar Association, Attorney William Fitzgerald, regarding the American Medical Association/American Bar Association Drug Education Program for middle school aged students. This program has been endorsed by the Hampden District Medical Society and the Hampden County Bar Association. The intent of this program is to educate our youths about the dangers and risks of illegal drug use. The plan is to have physician/lawyer teams meet with small groups of middle school aged children in various forums and to present them with factual, honest information regarding the consequences of illegal drug use.

The lawyer will concentrate on the legal ramifications of illicit drug use and some of the penalties that might be imposed as the result of such use. The physician will provide factual information regarding the effects of illicit drug use and the deleterious effect that it can have on the person's body. The small group settings will allow for much give and take and time to answer all the questions that the students might have as a result of the presentation.

It is hoped that the positive role models that these teams will demonstrate, as well as, the factual information they



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will impart, will help the students make a responsible decision for themselves regarding illegal drug use.

The Massachusetts Medical Society is providing the educational specialist, who will teach the physician/lawyer teams how to present the information to the students. The items will be coached about how to dress, speak, and make their explanations believable to the students they are attempting to reach.

The first prototype will take place at the Westfield Boys & Girls Club in February. There is a need to make similar presentations in the schools of all the cities and towns of Hampden County including Springfield, Holyoke, West Springfield, etc. If you are interested in participating, please call the Hampden District Medical Society and let us know. It does not require a great commitment of time; only one evening for a training session and then one school presentation. All you need to know will be covered during the training session, so there is no excuse not to join us in this very worthy project.

I think it is important to participate in programs such as these to show the community that we, as physicians, and as an organization, are very concerned about the scourge of drug abuse that is ripping apart the fabric of our society. A second reason for the importance of our participation is the possible tangible benefit that one child may decide not to use illegal drugs. This American Medical Association/American Bar Association drug education program will be exciting for the participants, as well as, doing a great good for our community. I invite all of you to join with us and participate in this worthy program for the betterment of our community. ■

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Worcester County Living Memorial Hospital

In 1967 the Vernon Hill American Legion Post 435 in Worcester, Mass. held several meetings with Worcester County Vietnam Gold Star Mothers. After these meetings, the post led a drive to raise funds to build a hospital in the village of Tung Nghai in the Central Highlands of Vietnam as a "living Memorial" to Worcester County soldiers who died or were missing in action in the Vietnam War.

The Gold Star families chose a hospital as a "Living Memorial" to their sons over the more traditional monuments and scholarships because a hospital seemed more appropriate to them at that time. Their sons had talked fondly about the Vietnamese people and the children, and the families wanted to do something that would help the people, especially the children, of that war torn nation.

Vernon Hill American Legion Post 435 Commander Francis R. Carroll contacted Dr. Jim Turpin, founder of Project Concern, who was then operating a medical relief clinic in the Central Highlands of Vietnam. Meeting with Dr. Turpin and the groups involved led to the decision to build a new fifty bed hospital to be named the "Worcester County Living Memorial" to be managed and staffed by Project Concern volunteers.

In February, 1970, the Hospital was officially opened.

The hospital is located in the village of Tun Nghai in the hamlet of Lien Hiep Tuyen Duc Province, in the Central Highlands of Vietnam, 140 miles northeast of Ho Chi Min City.

The *Good News* for everyone in Massachusetts who contributed twenty years ago to building the Project Concern "Living Memorial" in Vietnam is that, thanks to the efforts of so many committed people, the government of Vietnam has responded officially to Massachusetts inquiries and has released for the first time a very encouraging status report on the hospital in Lien Hiep.

Recently Francis Carroll, Chairman of the Living Memorial Committee was invited to New York to meet with Vietnam's Ambassador to the United Nations, Trinh Xuan Lang. Ambassador Lang arranged for Dr. James Turpin, the Project Concern doctor who ran the hospital for seven years, to return to Vietnam to visit the Living Memorial. Dr. Turpin reported the hospital has been operating on its own with no outside help since 1970. But it has badly deteriorated and is in need of medical equipment and supplies.

In a statement with national implications, Ambassador Lang said it is time for reconciliation. The Vietnamese government wants to cooperate with the people of Massachusetts on the hospital. They told Mr. Carroll and Dr. Jim Turpin how much they respect the hospital as a Living Memorial, and they welcome the Committee's renewed efforts to breath new life into the hospital.

If you have equipment or supplies that the Memorial Hospital might use, please contact:

Mr. Francis R. Carroll
554 Main Street, Box 1441,
Worcester, MA 01601
Phone: (508) 756-3513

Mary Lane Hospital

This is the Twelfth in a continuing series of articles featuring Western Massachusetts Hospitals

Mary Lane Hospital, located in Ware, Massachusetts, was founded in 1909. The hospital, accredited by J.C.A.H.O., provides a full range of acute care services to people in Ware and 11 neighboring communities, spanning three counties. The hospital's governing body is made up of individuals residing in the hospital's service area.

The hospital's medical staff is comprised of over 60 physicians representing a wide range of specialty services. The hospital employs over 300 health professionals and support staff members to assist physicians in providing health care diagnosis and treatment.

The technology available to the physicians is impressive. The Radiology department provides CT Scan, Realtime Ultrasound, low dose Mammography and Nuclear Scanning, along with conventional radiographic diagnostics. Laparoscopes, lasers and microscopes available in surgery allow surgeons to perform many of the advanced surgical procedures practiced today. Many of these procedures are performed in the Hospital's Same Day Surgery Unit, which is well utilized.

The Laboratory is well staffed and equipped to provide 24-hour testing capability. Courier and Fax services help in expediting timely reports of laboratory findings to physicians.

Mary Lane Hospital is unique in many ways as a community hospital—Responding to the community's desire to continue maternity services in Ware is just one example. The hospital recognized that parents want their babies born close to home in as natural a setting as

possible, but in a medically safe environment; and, demonstrating that it wanted to continue being part of that experience, completed a new modern and home-like maternity unit where the newest birthing methods and concepts are made available to patients, including combined Labor, Delivery and Infant rooming-in accommodations.

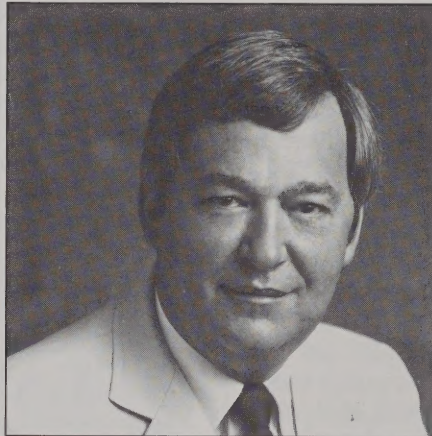
The 24 hour a day Emergency Department is staffed with physicians and nurses certified in Advanced Cardiac Life Support and Advanced Trauma Life Support. Mary Lane Hospital's well trained and caring staff, modern facilities and equipment, ancillary services and transport systems enable them to handle the most severe emergencies. 13,000 patients sought treatment in the Emergency Room last year. Mary Lane also maintains a Helipad to receive and transport patients by helicopter

for "Life Flight" of Worcester and "Life Star" from Hartford. The hospital was first in the area to build a helipad so that patients in need of extensive care could be transferred to a tertiary hospital.

The hospital's new, well staffed and equipped Intensive Care and Step-Down Units provide a level of acute care not available in some community hospitals.

Mary Lane reaches out to the community with several programs. The Visiting Nurse Program is a vital force in the community. Nursing and Home Health Services are provided to chronically ill or impaired patients at their residence, according to a plan of treatment prescribed by a physician.

An Adult Day Health Care Program was established



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to provide "A home away from home" for the elderly and health impaired individuals. Program staff provide medication, therapy and nutrition services to an increasing number of elderly people. The goal of the program is to provide a healthy, safe and nurturing environment to meet the daily needs of residents who would otherwise have to be placed in nursing homes. The hospital has a Certificate of Need to build a nursing home which is desperately needed in its service area.

The hospital offers a variety of health screenings, such as cholesterol levels, blood pressure, diabetes, glaucoma, as well as many health education programs. There are many specialty services available to patients in the Out-patient clinic ranging from Oncology to Podiatry.

An Occupational Health Program provides medical assistance for health-related needs of employees of area business and industry employers. The program under the direction of a registered nurse provides an array of health services custom designed for any size or type of business. These services help employers provide more healthful and safer environments for their employees, improve morale, reduce absenteeism and lost time from compensation claims, and aids in identifying and complying with federal health and safety standards.

The hospital is one of the most efficient hospitals in the State and the staff works hard to maintain efficiencies; but quality of patient care and concern for patients is the top priority at Mary Lane, where health professionals strive to provide the best medical treatment in a caring and comfortable environment. Weekly testimonials in newspapers and letters to staff and administration from former patients are evidence of the quality of care received at Mary Lane. One letter received recently from an Emergency Room patient from Connecticut wrote regarding her follow-up visit in her hospital, "I was ready to drive 2½ hours back to Ware and your supportive staff, and the best quality, competent care ever given." We are reminded of the many ways that the hospital and our staff ultimately effect the lives and well being of many people. While we are appreciative of this kind of testimony, we are also mindful of the growing threat to health care providers in general, and the need to search for better more cost effective ways of delivering health care to our communities. With this in mind, hospital leadership is committed to developing linkages in the health care industry that will assure its ability to continue to respond to the health care needs of the people it serves. ■

IN MEMORIAM

ROBERT J. MORIARTY, M.D., passed away October 26th, 1990. A native of Chicopee, he graduated from the University of Vermont Medical School. He was a past president of the New England Allergy Society. He leaves his wife, the former Jane L. McAuliffe; two sons, and eight daughters. Contributions in his memory can be made to the Mercy Hospital medical library. ■

Stanley T. Winer Robert M. Frye

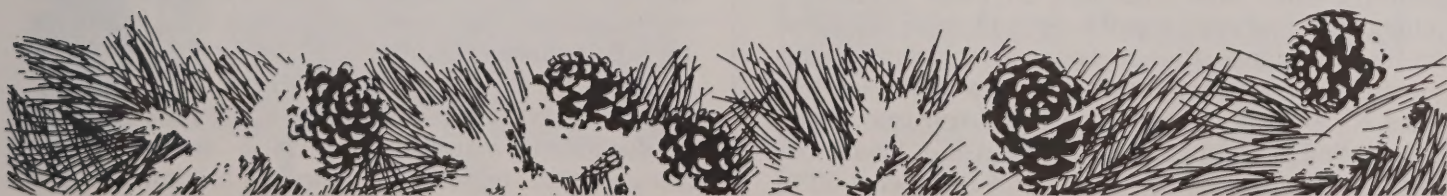
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Elimination of Preventable Blindness from Diabetes by the Year 2000

Twelve million Americans have diabetes mellitus. In addition to being a major cause of morbidity from multi-system complications, such as renal failure, neuropathy, and cardiovascular disease, diabetes is the leading cause of blindness among working-age Americans. It accounts for at least 12% of new cases of blindness every year in the United States. Diabetic retinopathy is often asymptomatic at its most treatable stage, emphasizing the importance of early diagnosis. New information about diabetes emerges almost monthly, making it mandatory for us to find better ways to keep up with advances in this field—the stakes are simply too high to do otherwise.

In response to the increasing importance of the overall problems of diabetes and diabetic retinopathy, and the availability of improved treatment regimens defined by published clinical trials, the American Academy of Ophthalmology (AAO) has embarked on a long-term education project designed to more rapidly translate research findings to medical benefits for the American public. The new project—"Elimination of Preventable Blindness from Diabetes by the Year 2000"—or "Diabetes 2000"—was announced at the AAO's 1989 Annual Meeting.

Facts About Diabetic Retinopathy

The majority of diabetic patients have non-insulin-dependent diabetes mellitus (NIDDM, Type II). Usually diagnosed after age 40, Type II diabetic patients may or may not be treated with insulin. Fewer patients have insulin-dependent mellitus (IDDM, Type I), which is usually diagnosed before age 30. Type I diabetics experience more frequent and severe ocular complications. After 5 years, 23% of Type I diabetic patients have retinopathy; after 10 years, almost 60% have retinopathy; and after 15 years, 80% have it. Proliferative diabetic retinopathy (PDR)—the most threatening form of retinopathy—is present in 25% of Type I patients after 15 years and often remains asymptomatic well beyond the optimal stage for treatment.

An estimated 700,000 Americans have proliferative diabetic retinopathy and 500,000 have macular edema. The annual projected incidence of new cases of PDR and macular edema is 65,000 and 75,000, respectively. About 8,000 new cases of blindness a year in the United States are caused by complications from diabetes.

What Can Be Done

"Diabetes 2000" provides the means to close the gap between advances in research and changes in treatment patterns. While most physicians are aware of diabetic retinopathy, the AAO's goal now is to focus attention on the importance of early diagnosis and timely treatment based on the important advances of the last 5-10 years. For example, we now know that timely laser photocoagulation surgery can reduce the risk of visual loss from proliferative diabetic retinopathy by at least 50%. We know that timely laser photocoagulation surgery of

diabetic macular edema can reduce the risk of moderate visual loss by 50%. We know that vitrectomy can restore useful vision to some diabetic patients who have advanced diabetic retinopathy.

Effective Partnerships are Needed

"Diabetes 2000" will be a long-term project aimed at a specific disease: diabetic retinopathy and its complications. Several phases are anticipated. Providing the latest research findings to ophthalmologists and other physicians who care for those patients is the first priority, followed by patient and public information. Initially, new advances and treatment guidelines for the medical and surgical treatments of diabetic eye disease will be emphasized through continuing education of ophthalmologists, other physicians, allied health professionals, residents, medical students, and specialists in diabetes-related education. In later phases, educational programs for diabetic patients and the public will be developed. Ultimately, improved eye care of diabetic patients is expected as a result of closer collaboration between the primary physician, the patient, and the ophthalmologist. Since diabetic patients can be asymptomatic despite significant progression of diabetic retinopathy, the importance of a renewed and improved partnership between the ophthalmologist and the primary physician is critical.

Because of the ambitious goal and long time-frame, many other medical organizations and public groups are involved in "Diabetes 2000". Representatives from various medical specialties, government agencies, and other organizations devoted to problems of the diabetic patient have been invited to participate. Since diabetes is a complex disease whose overall management is the responsibility of physicians other than ophthalmologists, "Diabetes 2000" will stress involvement of other physicians and medical specialty organizations in the planning and implementation of the project. The importance of finding ways to develop effective partnerships between the patient's primary physician, the ophthalmologists, and the patient in the management of diabetic eye disease is a major goal. Another important aspect of the project is the identification and promotion of existing diabetes eye health programs around the country, such as the Center for Disease Control (CDC) Diabetes Translation Project. The AAO will encourage ophthalmologists to participate in national, regional, and local programs that are already in operation, as sponsored by such organizations as the American Diabetes Association, the Juvenile Diabetes Foundation, Lions Clubs, and others.

Massachusetts Ophthalmologists are Participating

Educational materials are being developed and demonstration projects are underway in some states to encourage ophthalmologists and other physicians to

participate in continuing education programs concerned with the overall management of diabetic retinopathy. A Preferred Practice Pattern on diabetic retinopathy is available through the offices of the American Academy of Ophthalmology (415-561-8500). This document provides the latest information concerning the management of diabetic retinopathy. The Massachusetts Society of Eye Physicians and Surgeons is actively involved in this national initiative. Ophthalmologists in Massachusetts are eager to help develop the necessary educational and service programs that will achieve this goal.

Diabetes 2000 will parallel a major diabetic retinopathy public information campaign recently announced by the National Eye Institute. The NEI's National Eye Health Education Program (NEHEP), which targets both diabetic retinopathy and glaucoma, is fashioned along the lines of earlier federal initiatives against smoking and high blood pressure.

By continuously updating our medical knowledge and skills related to this multi-system disorder, and by forging partnerships between physicians in the effective and efficient management of diabetic patients, we have a unique and important opportunity—we can reduce preventable blindness from diabetes by the year 2000. ■

Sheldon M. Buzney, Jr., M.D., President
Massachusetts Society of Eye Physicians and Surgeons

Ronald E. Smith, M.D., AAO Secretary for Continuing
Education Diabetes 2000 National Project Director

Arnall Patz, M.D., Past President, AAO Diabetes 2000
National Chairperson

1. Kupfer, C.: The challenge of transferring research results into patient care. *Ophthalmology* 96:737-738, 1989.
2. Preferred Practice Pattern: Diabetic Retinopathy, American Academy of Ophthalmology, 1989.





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- Twenty-five percent to 30 percent of all low-level radioactive wastes produced in the U.S. results directly from medical uses.
- About 120 million nuclear medicine procedures contribute annually to low-level radioactive waste production.
- Research is a significant contributor to low-level radioactive waste production. For example, radioisotopes are used in the development and evaluation of about 90 percent of all new drugs.

Universities, medical schools, hospitals, laboratories and medical practices are among the producers of low-level radioactive wastes. Their activities clearly benefit individual patients and society as a whole.

Political, not public health problem

Then why is disposal of radioactive wastes a problem?

Actually, disposal has long been more a political than a public health problem. In the 1960s, six licensed commercial facilities closed, opposition developed in the three remaining host states on the grounds that they should not be burdened with the disposal needs of the entire nation.

In response, Congress passed the Low Level Radioactive Wastes Policy Act in 1980. Under this bill, each state would eventually become responsible for disposal of radioactive wastes generated within its boundaries. The act recommended that states participate in regional groupings or compacts to improve the cost-effectiveness of disposal facilities. It also stated that any regional facility could exclude wastes from outside its region after Jan. 1, 1986.

States make slow progress

For the next five years, states moved to negotiate compacts and sign the necessary agreements. The difficulty in locating and gaining approval for disposal sites slowed progress. Remote sites might satisfy public sentiment, but their remoteness complicated disposal convenience and cost.

By 1985, it was clear that states would not meet the 1986 deadline. Congress responded with amendments to the Wastes Policy Act, extending the deadline to Jan. 1, 1993. On that date, the three existing commercial sites—located in Beatty, Nev., Richland, Wash., and Barnwell, SC.—will be closed to outsiders.

State negotiations have proceeded since 1985. Yet selecting a disposal site and preparing to operate a facility involves a complicated series of steps. In its 1988 informational report, ("Low-level Radioactive Wastes," August 4, 1989, Vol. 26, No. 5, pp. 669-674, *Journal of the American Medical Association*) the American Medical Association Council on Scientific Affairs said those steps include legislation, government oversight, public participation, financing, engineering, supervision, surveillance and quality control. Few states are far along in this process and fewer still are expected to meet the 1993 deadline.

Physicians can help

Physicians can play a key role in helping their states develop acceptable disposal facilities for low-level radioactive wastes. Their medical training can provide an informed perspective on the personal and public health risks related to waste disposal. But more importantly, they can describe the beneficial uses of procedures that produce radioactive wastes and how these uses will be compromised if disposal sites for the wastes are unavailable.

Consider becoming involved in efforts to establish disposal facilities. First, contact representatives of your state's radiation control program or health agency. Arrange to meet with them, determine whether your state is involved in a compact, and offer your support. Encourage these representatives to consider what will be done if a disposal site is not available by Jan. 1, 1993. Stress the need to develop one or more storage sites for low-level wastes as an intermediate measure until a disposal site becomes available.

Secondly, encourage your medical society's public health or environmental health committee to become involved. Pass policy regarding the disposal of low-level radioactive wastes and then promote it. Through lobbying efforts or by working with public health authorities, the medical society can influence disposal facility plans.

Finally, physicians can help persuade their patients, the media and community groups that radioactive materials can be beneficial. Seek opportunities to lead discussions in classrooms or speak to public audiences.

For further information, contact the Division of Biomedical Science (J. Loeb, PhD, Director), American Medical Association, 515 North State Street, Chicago, Illinois 60610; (312) 464-5456. ■

Carla Brock, Communications Consultant
Department of Consulting Services
American Medical Association

The Federal Americans With Disabilities Act And Employment Issues

EDITOR'S NOTE: *Kevin M. Sweeney, is an attorney with Bulkley, Richardson and Gelinis, Springfield, MA 01115*

On July 26, 1990, The Americans with Disabilities Act (The "ADA") was signed into law. The ADA is the most far-reaching federal provision to date, for the purpose of protecting the civil rights of persons with disabilities. Title I of the ADA primarily addresses employment issues, while other provisions of ADA address additional concerns of the disabled, such as physical accessibility and limitation of health care benefits based on certain medical diagnoses. This article is a general overview, (and by no means a complete description) of Title I of the act.

As employers and as participants in employment decisions, physicians should be aware of the ADA and its requirements. Generally, most doctors already utilize employment and other practices which are consistent with the goals of the act. Nevertheless, before making employment and related decisions, it is worth understanding what is and is not allowed by the ADA.

Title I of the ADA prohibits discrimination by employers, employment agencies and other similar entities against "qualified individuals with disabilities" regarding any term, condition or privilege of employment. The act further provides that an employer must make reasonable accommodations for individuals with known disabilities, unless such accommodation would create undue hardship for the employer. Where an employer has violated the ADA, an employee may bring an action before the federal administrative agency known as the Equal Employment Opportunity Commission ("EEOC") and may pursue further litigation in the federal courts.

It is important to understand some basic definitions in the act. First, the ADA affects only "covered employers," that is employers who have 25 or more employees per each working day in each of 20 or more calendar weeks in the current or preceding calendar year. However, after July 26, 1994, all employers of 25 or more employees are bound by the law. Under this definition, most physicians in solo practice or small to medium-sized group practices probably are not subject to the restrictions of the ADA, since they would not exceed the threshold number of employees. Nevertheless, many physicians, who may not be covered employers themselves, may do preemployment or other work-related physicals on behalf of covered employers and thus should be aware of the ADA and its provisions.

Second, a "qualified individual with disability" is "an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position." A disability is defined as a physical or mental impairment that "substantially limits one or more of the major life ac-

tivities" of a person. The employer, however, has some discretion in determining exactly what the essential functions of the job are.

"Reasonable accommodations" can include job restructuring, modification of work schedules or equipment, reassignment to other available positions, and other similar changes. However, an employer is only required to make reasonable accommodation if it will not create an undue hardship on that employer. An undue hardship is an action requiring significant difficulty or expense in light of the cost and nature of the accommodation and the resources of the employer. In other words, a group practice is not necessarily going to be required to rebuild its office space for one employee, if such a plan were overly burdensome on the practice.

Nevertheless, the best advice one can give regarding accommodation issues and the avoidance of potential problems in the face of this new law is to continue to be flexible and concerned about employees with special needs. Maybe some alternative accommodation will not create any significant hardship for the employer and yet will fulfill the reasonable accommodation requirement. Always document any attempt to accommodate a disabled employee, including the costs associated with it. Most importantly, be accurate, realistic and up-to-date with any job descriptions. A vague or inaccurate job description complicates future consideration of whether reasonable accommodation has been attempted.

Much of the advice and many of the provisions and definitions described above may seem familiar, as they are quite similar to Chapter 151B of the Massachusetts General Laws, which for several years has prohibited discrimination against persons with disabilities. In fact, the Massachusetts statute already covers more employers and probably impacts more practitioners, because it applies to employers with six or more employees, a much lower threshold than is contained in the ADA. Therefore, any doctor or group practice that has not faced problems under the state statute will probably rarely, if ever, encounter any dilemmas involving the ADA.

However, it is important to note that the ADA does not replace the Massachusetts statute. Where Chapter 151B may apply stricter standards than the ADA, state law can and will continue to apply. Furthermore, Chapter 151B provides a mechanism for hearings before the Massachusetts Commission Against Discrimination ("MCAD"), an agency which is similar in purpose to the federal EEOC. Presently, an employee claiming discrimination on the basis of a handicap must first present the matter to the MCAD for a hearing before presenting the matter to a court, and this avenue to litigation will continue to be available to potential claimants,

continued

The Federal Americans With Disabilities Act And Employment Issues

continued

in addition to the avenues created by the new federal law.

Additional avenues for litigation will pose no threats to employers, if care is taken to comply with all applicable standards. In this regard, employers should be aware of particular issues which they might face pursuant to Title I of the ADA.

Neither the ADA nor other laws bar an employer's ability to hire the best qualified individual for the job. However, employers should be sensitive to the types of hiring procedures they utilize. An employer may make preemployment inquiries about a potential employee's ability to perform job-related functions. However, an employer cannot routinely ask an interviewee about the existence of a disability where a disability is unrelated to the functions of the job to be filled.

In addition, doctors who require applicants to have preemployment medical examinations or those who perform preemployment medical examinations for other employers, should be aware of certain basic guidelines regarding such procedures. First, an employer may only require a physical examination and condition employment on the outcome of the physical after an offer of employment has been made and before commencement of work, if (a) all entering employees are subject to such a physical; (b) information collected is regarded as a confidential medical record (except that supervisors may be informed of work restrictions, first aid and safety personnel may be informed and government officials investigating ADA compliance may be informed); and (c) the results of such a physical are used in compliance with applicable laws and are not used in a discriminatory manner.

Second, physical and mental testing must be job related, and the purpose of any such examinations must be made clear to the applicant. Under the ADA, a medical opinion cannot appear to be arbitrary. Thus doctors performing preemployment physicals should carefully document the clinical basis for an assessment of individuals potentially protected by the ADA.

As is probably apparent from this discussion, Massachusetts doctors have little work to do in preparation for the ADA's effective date. Massachusetts anti-discrimination laws have similar or stricter standards, and many of the requirements of the ADA are just good common sense. In the end, employers can continue to choose the best qualified person for the job. Antidiscrimination laws are intended not to impede, but to further that goal by ensuring that persons with disabilities will be able to participate in the workplace. ■

HIV Drug Reimbursement Plan

Dear Colleague:

I would like to take this opportunity to update you on the HIV Drug Reimbursement Plan and to request your help in publicizing the continued availability of funds, and the addition of gancyclovir and fluconazole to the list of drugs now covered by the HIV Drug Reimbursement Plan.

Until now, we were authorized to pay only for AZT, aerosolized pentamidine, and alpha interferon.

Recently, the federal government approved the inclusion of gancyclovir and fluconazole on the list of drugs we can pay for as part of AIDS therapy.

Coverage for fluconazole will be limited to one specific indication, i.e. cryptococcal meningitis.

The program is intended to help individuals who either have no insurance or insufficient coverage for these medications. All individuals in need of financial assistance for either AZT, aerosolized pentamidine, alpha interferon, gancyclovir and fluconazole are encouraged to apply. As always all inquiries are kept in strictest confidence.

Our goal is to reach more individuals throughout the state who are in need of our services.

Once again we thank you for your help in directing individuals in need to the HIV Drug Reimbursement Program. ■

Sincerely,
Joseph Montanez
Enrollment Coordinator

CORRECTIONS & ACKNOWLEDGMENT

The Regional Column for the November/December issue of the Hampden Hippocrat stated that there were approximately 500 nonmember physicians within the district. This number is inaccurate, as it include physicians who have left the area, are retired or deceased. The actual nonmember physician base in the Hampden District is approximately 198.

The November/December Hippocrat contained an article on the Springfield Quits Smoking Project. The Project Coordinator for the Springfield Quits Smoking is Ms. Kimothy Jones. We apologize for listing her name as "Timothy".

When Is Enough Enough?

The sixth annual Medical Ethics Seminar, sponsored by the Hampden District Medical Society, was held October 24 at Mercy Hospital. Peter T. Demos, M.D., chairman of the Medico-Religious Committee, introduced the event.

Reverend Bruce K. Benander, the pastor of Bethesda Evangelical Lutheran Church and a member of the Medico-Religious Committee, introduced the guest speaker, Reverend Stanley S. Harakas, professor of Christian ethics at Holy Cross Greek Orthodox School of Theology.

Physicians must revise their self-image in the light of new technology and economic constraints, said Harakas. The notion that death is "failure" must be confronted and revised.

Reverend Harakas discussed ecumenical dialogue; we need to share our various perceptions, and to understand where we are coming from, but at the same time, we have to guard against the pain of dialogue; after all, our ideas and convictions are precious to us, and people who hold differently represent threats to these. Avoiding dialogue averts the pain, but we then lose valuable insights and the opportunity for growth.

From a theologic standpoint, Reverend Harakas explained that central to Greek Orthodox belief is the concept of God as a Trinity—that is, a community of persons living in unity. In the Judeo-Christian tradition, man is made in God's image, and as such, we are not complete except insofar as we are part of a community. Greek Orthodox theology also sees creation as a whole, that everything in life is connected. As such, although we are free to choose, our decisions affect the whole network of connections. This is the paradox of freedom and mutual dependency.

The American ideal of the individual unfortunately diminishes some equally important ideals; namely, responsibility to the community, and a transcendent

reference (God, universal ideals,—namely, something bigger and more important than the individual).

When we ask the question "Who decides?" we imply that a person does the deciding, and this means other persons do not—there is a competitive flavor to the question. Alternatively, the question implies that for some there is no responsibility for a decision. But decisions have to be made more and more in a corporate fashion.

In our United States, unlike most other societies, we do not share a universal value system; we do not have generally recognized authority structures; and finally, the rate of change is more rapid in our country than others. For all these reasons, our decisions about who decides and how decisions are made must be *conscious*.

When we make a decision, we must consider:

- a) What is the end result desired?
- b) What are our motives (which may be different from the result we desire)?
- c) What are the consequences of our decision on the larger pattern?
- d) What values are promoted; what values are compromised?
- e) Are the means to implement the decision appropriate?

Ethicists may look at moral questions in different ways:

Good vs. Evil—this is philosophical; has broad connotations; often is not practical.

Right vs. Wrong—this has immediacy; is sharp and practical; but does not really help in developing general principles.

Fitting vs. Unfitting—in this context, we look for harmony or disruption as a consequence of the decision; in a sense, this analysis is the most holistic.

Ethical decision making must be recognized as imperfect; we will never come to a "perfect" answer.

continued

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When Is Enough Enough? *continued*

In early times, the Greek Orthodox church developed a ceremony called "The Service for the Tearing Away of the Soul." The church has an elaborate set of rituals for praying for healing; but when it was recognized that healing was no longer a possibility, there was a shift in context, which was recognized by this ceremony. We must be able to recognize these changes in context; a feeding tube may have been appropriate yesterday, but now it is no longer appropriate.

In every case we analyze, we need to make our decisions based on the specifics of each case.

Three examples:

a) An elderly man had been resuscitated twice. The third time the patient arrested, the family had to almost physically restrain the medical staff from another attempt at resuscitation.

b) Another elderly man lost his hearing. He began to decline and ultimately died, and an autopsy did not adequately explain why death had taken place.

c) An elderly lady was diagnosed with cancer; her physician felt nothing significant could be accomplished medically, and she and her two children agreed with this, and she eventually expired at home peacefully.

The first case represents the conflicts that can exist; here there was disagreement between the family and the medical staff about who should make the decision. In the second situation, the patient himself seems to have made the decision to die. In the third case, the decision process was "fitting" in that it was shared, it was appropriate, etc.

Reverend Harakas ended his discussion by summarizing his main points:

a) Religious values and interests should be involved in the decision-making process.

b) The process should involve as many people as possible, eg, family, medical staff, patient if possible, clergy, etc.

c) It is extremely important when making these types of decisions to keep the whole context in mind; changes in the situation change the moral meaning of the decision.

The presentation was followed by small group discussion of a particular case, and by comments from the panel, made up of Sister Mary Caritas, Chief Executive Officer of Mercy Hospital; Matthew L. Leahey, President of Ring Nursing Homes; William D. Kiss, M.D., and Cathy J. Jones, a professor of law at Western New England College. ■

Donald J. Higby, M.D.

Hampden District Medical Society Auxiliary Update

The HDMS Auxiliary is continuing to operate under the direction of a Presidium with positions filled as follows: Lynn Papale, Secretary; Susan Krasner, Treasurer; Patricia Tinervia, Health Education Chairperson; Susan Burstein, Social Chairperson; Joan Hampf, Scholarship Program Chairperson and Diane Goodman, Scholarship Program Treasurer.

Our annual membership drive began in the fall and is ongoing. We are very encouraged by the number of new members who have been recruited over the past two years. Anyone who is interested in joining the Auxiliary should contact a member of the Presidium.

Susan Burstein, Social Chairperson, has been working on three social events for this year. The first, a fall breakfast, was held in November and attended by approximately 50 members. A late winter event and a spring function are also planned.

Patricia Tinervia, Health Education Chairperson, has developed a program and materials which can be used to teach health and body awareness to elementary school children. Anyone interested in using this information should contact Patricia.

Our annual scholarship drive, managed by Joan Hampf and Diane Goodman, is now underway. Last year, the Auxiliary was able to award six \$500 scholarships to individuals studying in health related programs. We hope to be able to do the same this year and are very appreciative of any financial support to this fund.

A committee is currently being formed for a two year Auxiliary project involving raising funds and increasing the number of donors for the National Bone Marrow Donor Foundation. Anyone interested in working on this committee should contact a member of the Presidium.

The Auxiliary sponsored a Christmas/Holiday card sale again this year with all profits going to the National Bone Marrow Donor Foundation. This sale will be held annually.

The Auxiliary is also working in conjunction with the HDMS to collect clothing, furniture, bedding, nursery and play equipment, etc. for some of the area shelters. Anyone who has anything to donate is encouraged to contact a member of the Presidium or Carol Nystrom at the HDMS office. ■

Lynn Papale

Retirement Plan Distributions

ABOUT THE AUTHOR: *Michael A. Potito is a financial planner at R.P. Zampiceni Associates, located in West Springfield, MA.*

You have probably accumulated a substantial "nest egg" in your retirement plan. If you are like most people, you are counting on this "nest egg" as a major source of income during retirement.

That is why you want to be sure you make a considered well-informed decision about what to do with your retirement plan money.

You will want to consider all the distribution options and, perhaps more importantly, their income tax consequences. You will want to carefully examine your investment alternatives as well, since these assets cannot be easily replaced; especially if you are retiring.

At your retirement you will be facing one of the most important financial decisions you will ever have to make. And the choices you make at retirement will have a significant impact on your future.

The remainder of this article is intended to address the options you have when you take your retirement plan distributions and what the tax consequences will be as a result of your decision regarding your choice of distributions.

Your first choice will usually be, should you take your plan benefits as a series of monthly installments or should you take a single lump sum.

Although there are many variations, the most common installment series payment method chosen is a lifetime benefit method. If you are single, payments continue for your life and if married, payments continue, under a joint and survivor schedule or method, until both you and your spouse have died (the monthly benefit is usually reduced after the death of the plan participant).

The advantage to the lifetime installment payment method is that your monthly payments are usually

guaranteed therefore, you cannot outlive your benefits.

The disadvantages are once you have chosen an installment payment option, the election cannot be revoked. Additionally, you relinquish control over your retirement assets, any unused portion of the assets may not be available to pass on to beneficiaries (other than your spouse) and monthly payments are usually calculated on comparatively low earnings assumptions.

A lump sum distribution represents the entire vested account balance from your retirement plan. It becomes available only when you separate from service either by retirement, termination of employment or if your employer terminates the plan.

The advantages of a lump sum distribution are significant. For instance, you have the flexibility to select investments that may allow you to duplicate the monthly installment income by simply living off the interest from your retirement plan assets. Because of the very conservative investment assumptions retirement plans normally use when determining your monthly payout, even some conservative investments may allow you to match pension income without depleting principal. And with the lump sum payment method, you can pass any unused assets to your beneficiaries.

In short, if you prefer immediate access, more flexibility and more control over your retirement assets, you will probably find a lump sum distribution more appealing.

The obvious disadvantages to a lump sum distribution are your monthly income is not guaranteed and you could outlive your benefits; especially if you tend to overspend or select a poor money manager.

Now let's examine the income tax aspects of both the installment monthly payment method and the single lump sum distribution method.

Quite simply, with the installment monthly payment

continued

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Retirement Plan Distributions *continued*

method, you pay ordinary income taxes as you receive the payments.

On the other hand, the lump sum distribution method requires careful consideration of the income tax aspects.

First of all, if you took a lump sum distribution because of termination of employment and you were under age 59½, you would probably roll the money over to a rollover IRA, thus, avoiding taxation until such time that you actually took distributions. If you did not place the money into a rollover IRA, you would be subject to a 10% premature distribution tax and the entire amount would be subject to ordinary income tax. At age 59½, the 10% premature distribution tax is eliminated. There is one exception to the 10% premature distribution tax rule. If your employers plan allows for early retirement (at least age 55), you may withdraw the money without the 10% premature distribution tax being imposed.

For the following discussion, let's assume that you plan to retire and you are at least age 59½.

Again, you could place the money into a rollover IRA. You could then invest the money as you saw fit and live off the interest earnings, thus, pay income taxes on the earnings only. Once you reach age 70½, you would also have to take at least a minimum distribution amount under a predetermined schedule established by the IRS.

Another option is to take a single lump sum distribution and pay the income taxes when you receive the money. With this option you may qualify for favorable tax treatment with 5 or 10-year forward income averaging. In order to qualify for 5 or 10-year forward income averaging, you must have participated in your retirement plan for at least five years. The distribution must be a lump sum payout within one tax year. You must be at least age 59½ to qualify for 5-year forward income averaging and if you were at least 50 years old on January 1, 1986, you could qualify for 10-year forward income averaging.

Another factor that deserves consideration, is that the IRS levies a 15% excess withdrawal excise tax when qualified plan distributions exceed a certain threshold (including IRA distributions). Generally, the law states that when an annual withdrawal from your qualified plan or IRA exceeds \$150,000, a 15% excess withdrawal excise tax will be imposed upon the dollar amount that exceeds \$150,000. It is important to note that this tax is on a per employer basis. For example, let's assume that you take \$120,000 from the qualified plan established by your practice, you also take \$120,000 from a TSA established by the hospital you worked at, prior to going into private practice and you take \$180,000 from your personal IRA. Given these circumstances, the 15%

penalty tax would be imposed on the distribution from the IRA only, on the amount that exceeds the threshold of \$150,000. In other words, the 15% excise tax would apply to \$30,000 of the IRA distribution.

The 15% excess withdrawal excise tax also applies to lump sum distributions. Generally, the law states that for lump sum distributions that exceed \$750,000, the excise tax will be imposed upon the dollar amount that exceeds \$750,000. Unlike the annual distribution rule that applies on a per employer basis, the lump sum distribution rule aggregates payouts of all qualified plan money. For example, let's assume that you receive \$350,000 from your current employers qualified plan, \$300,000 from a TSA (tax sheltered annuity) and \$200,000 from an IRA, all in the form of a lump sum income taxable distribution. Because the aggregate total of all payouts exceeds the \$750,000 threshold, the difference (\$850,000-\$750,000) or \$100,000 would be subject to the 15% excise tax.

The above 15% excess withdrawal excise tax applies to tax payers that did not elect for a grandfathering provision in the tax code by 4/15/89. There is another set of rules that applies to those that did elect the grandfather clause. This topic deserves its own lengthy discussion and will not be covered in this article.

The following table compares 5 and 10-year forward income averaging for lump sum qualified plan distributions, to ordinary income taxes on income from other sources.

Lump Sum Distribution	Federal Tax 10-Year Averaging	Federal Tax 5-Year Averaging	Normal Tax 33% Rate	Normal Tax 28%Rate	1991 Normal Tax 31% Rate
20,000	1,100	1,500	6,600	5,600	6,200
50,000	5,874	6,400	16,500	14,000	15,500
100,000	14,471	16,398	33,000	28,000	31,000
250,000	50,770	58,398	N/A	70,000	77,500
500,000	143,682	128,398	N/A	140,000	155,000

In conclusion, it appears that, in most instances, a lump sum distribution from your employers qualified plan is more advantageous whether you pay the taxes under an averaging scenario or, you roll the money over to a rollover IRA.

Obviously, this is merely an overview. If you are planning to retire soon, I suggest you contact your financial advisor(s), prior to electing a retirement distribution method. It only makes sense to do so, as there are many considerations and tax implications that will result from your decisions. ■

Welcome New Members

Bishara M. Faris, M.D.
2 Medical Center Drive
Suite 205
Springfield, MA 01107

BORN June 12, 1934
PREMED: School of Arts & Sciences, American Univ. of Beirut 1951-1955
MEDICAL: School of Medicine, American Univ. of Beirut 1955-60
INTERNSHIP: American University Medical Center, Beirut 1959-1960
RESIDENCY: American University Medical Center, Beirut 1960-1963
FELLOWSHIP: Massachusetts Eye & Ear Infirmary and the Eye Research Institute of Retina Foundation, Boston 1963-1966
SPECIALTY: Ophthalmology

Thomas S. Kaye, M.D.
80 Congress Street
Springfield, MA 01104

BORN: July 24, 1952
PREMED: C.U.N.Y. (Queensborough-Brooklyn) 1970-1974
MEDICAL: Albert Einstein College of Medicine 1974-1978
INTERNSHIP: Montefiore Hospital, New York 1/78-6/78
Kings County Medical Center, New York 7/78-12/78
RESIDENCY: Kings County Medical Center, New York 1/79-6/79
Albert Einstein College of Medicine 7/79-1985
SPECIALTY: Neurosurgery

Margaret M. Beliveau-Ficalora, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: June 14, 1956
PREMED: Fairfield University, Connecticut 1974-1978
MEDICAL: New York Medical College 1978-1982
INTERNSHIP: Baystate Medical Center 1982-1983
RESIDENCY: Baystate Medical Center 1983-1985
FELLOWSHIP: Baystate Medical Center 7/88-1/90
SPECIALTY: Internal Medicine

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continued from previous page

Danielle B. Clair
224 Walnut Street
Holyoke, MA 01040

BORN: December 6, 1958
PREMED: Mount Holyoke College, Massachusetts
1987
MEDICAL: University of Massachusetts Medical
School 1994
STUDENT

Martin L. Gimovsky, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: February 16, 1950
PREMED: Columbia University School of
Engineering & Applied Science
1968-1972
MEDICAL: New York University School of Medicine
1972-1976
INTERNSHIP: Columbia-Presbyterian Medical Center
1976-1977
RESIDENCY: Sloan Hospital for Women/Columbia
Presbyterian Medical Center 1977-1980
FELLOWSHIP: Women's Hospital, LAC/University of
Southern California Medical Center
1981-1982
SPECIALTY: Maternal-Fetal Medicine/Obstetrics/
Gynecology

Donald A. Schwartz, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: January 24, 1958
PREMED: Columbia College 1974-1978
MEDICAL: Harvard Medical School 1978-1983
INTERNSHIP: Children's Hospital of Philadelphia
1983-1984
RESIDENCY: Children's Hospital of Philadelphia
1984-1986
Massachusetts General Hospital
1986-1988
FELLOWSHIP: Children's Hospital of Boston 1988-6/90
SPECIALTY: Anesthesia/Pediatrics

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How to Respond to a PRO Quality Inquiry

A message from the Department of Health Care Review, American Medical Association.

Utilization and Quality Control Peer Review Organizations, commonly known as PRO's, have entered into "The Third Scope of Work," i.e., the third round of PRO contracts negotiated between the Health Care Financing Administration (HCFA) and the nation's 54 PROs. Effective April 1, 1989, all PROs were bound by the new Scope of Work. Despite new contractual provisions in the Third Scope of Work, PROs still have as their primary responsibility the medical review of services reimbursed by Medicare. PROs review such services to ensure that they are: (a) medically necessary, (b) provided in an appropriate setting and (c) meet professionally recognized standards of care.

Quality Intervention Plan

Cases selected for review by PROs under the Third Scope of Work are passed through six generic quality screens, identical to those used in the Second Scope of Work. However, the Third Scope of Work rules also require the implementation of a Quality Intervention Plan (QIP). The QIP is a plan by which each PRO is required to perform a quality review and implement interventions when quality concerns are identified. The following is an overview of the QIP:

- Every Case selected for retrospective review is screened for potential quality problems.
- If a potential quality problem is identified, the QIP requires the PRO to allow 30 days for the physician and/or provider to comment on the proposed quality problem.
- A PRO physician reviews comments submitted within the specific timeframes in order to confirm or resolve the potential quality problem.
- When the PRO determines that there is a confirmed

quality problem, the PRO must determine the source of the problem and notify the affected party of the final determination. The notice to the responsible party must include sufficient detail so that he/she will clearly understand the identified problem, what the appropriate action should have been in the case, the severity of the problem, and the action to be taken to resolve the quality problem, if appropriate.

■ A PRO physician must assign a severity level to each case with a confirmed quality problem. The three-level severity system is based upon the degree of harm or potential for harm to the patient. The three-level severity system was developed with the assistance of physicians representing the major medical specialty societies. The three levels are:

- Confirmed quality problem *with* significant adverse effects on the patient (Level III);
- Confirmed quality problem *with the potential for* significant adverse effects on the patient (Level II); and
- Confirmed quality problem *without the potential for* significant adverse effects on the patient (Level I).

"Significant adverse effect" is defined as (1) patient management which results in anatomical or physiological impairment, disability, or death, or (2) unnecessarily prolonged treatment, complications, or readmission.

■ Each case with a confirmed quality problem is assigned a weight based upon the severity level of the problem. Each severity level has an assigned weight, from a weight of 25 for a level III problem, to a weight of 5 for a level II problem, to a weight of 1 for a level I problem.

■ Each quarter the PRO will profile the total weights accumulated for reviews completed in that quarter by problem source (e.g., physician and provider). The total weight will determine the corrective action to be implemented. When the quarterly profile shows that a

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How to Respond to a PRO Quality Inquiry

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particular physician has a total weighted score of three points or more, the PRO must initiate corrective action. The Third Scope of Work states that when a severity level II or III potential quality problem is identified or a pattern of severity level I potential quality problems are identified, the responsible party (i.e., the physician and/or provider as appropriate) will be notified of the potential quality problem and provided with an opportunity to respond and discuss the issue with a PRO physician. The initial notification should include sufficient detail so that the responsible party will clearly understand the identified problem and the severity of the problem.

How to Respond

Following is a list of steps to take if you receive a letter of inquiry regarding quality concerns from your PRO¹:

Step 1. Keep calm. Do not send angry letters back to the PRO; discuss the quality issue with a peer.

Step 2. Review the medical record to make sure the PRO hasn't made a factual error in its review of the case. The PRO may have overlooked a critical entry in the medical record.

Step 3. Physicians receiving letters of inquiry from their PRO should carefully consider whether or not to telephone their PRO about the case. A preferred course of action is to write to your PRO, with a copy to the chief of the

hospital staff, instructing the PRO to communicate its concern to the chief of staff and departmental chairman.

In your communication with your PRO, you should present factual information without self-serving statements, argumentative remarks, explicit or implicit admissions of error in judgement, or criticism of care provided by others.

Step 4. You may opt to request a personal interview with the district medical director and specialist consultant prior to writing a response; a personal interview may be more appropriate than writing, particularly in a complicated case.

Step 5. Keep your response in a separate file other than the patient's medical record. Keep all communications separate so that they are not inadvertently disclosed if the medical record is produced in response to a subpoena.

As always, detailed histories and patient records are important to keep; such detailed records help you to remember clearly relevant facts involved in the treatment. They may also explain to the PRO reviewer why you chose a particular course of treatment. ■

¹Step 3-5 were adopted with permission from the California Medical Association's brochure "What Physicians Should Know about Working with CMRI and Other Review Organizations."



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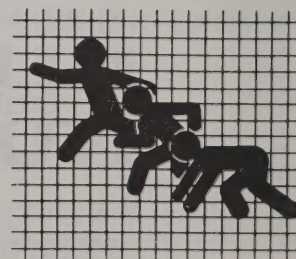
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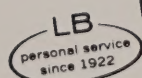
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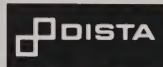
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